

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES WILLIAM ADAMS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 22, 1987</b>			2b. HOUR <b>0040 A</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 8, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VALLEY LEE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WATERMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
13a. STATE <b>MD.</b>			13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>DRAYDEN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM ADAMS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY STEWART</b>			13e. STREET ADDRESS / ZIP CODE <b>GEN. DEL. (20630)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-12-9773</b>		17. INFORMANT ADDRESS <b>BERNARD THOMPSON, DRAYDEN, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LUNG CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1 ym</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>Feb 3</b> , 19 <b>87</b> , to <b>Feb 22</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>Feb 21</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Bennett, M.D.</b>			22c. ADDRESS <b>Leonardtwn, MD 20650</b>			22d. DATE SIGNED <b>2/25/87</b>		22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/24/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE CATHOLIC</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CEM. VALLEY, ST. MARY'S MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 02 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial. Removal with the State Dept. of Health and Mental Hygiene is required.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

1000

January 23, 1947

General Hospital

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

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RECEIVED

045062 FEB 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medicolegal investigator must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 5 9 0 8  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
JOHN EDWARD ALDERMAN		February 14, 1987		10:53a	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
MALE	WHITE	MONTH DAY YEAR	92 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
FLOYD CO., VA.	USA		St. Mary's County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtwn	St. Mary's Hospital	SUPPLY DEPT.	CIVIL SERVICE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD.	ST. MARY'S	LEONARDTOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	CEDAR LANE APTS. #314 20650	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	ADDRESS			
Green T. Alderman	Eliz. J. Helms	618 KNIGHT COURT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	229-18-6221	A RUBY M. GRAY	LEXINGTON PARK, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Bronchopneumonia</u> (c) <u>Chronic Obstructive Pulmonary Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>hrs</u> <u>days</u> <u>yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>11</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERSTANDING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION	
AT HOME <input type="checkbox"/> IN THE WHOLE <input type="checkbox"/> AT WORK <input type="checkbox"/> ADVISORY <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I <u>did</u> <del>did not</del> ) attended the deceased from <u>1-85</u> to <u>2-14</u> 19 <u>87</u> that (I <u>am</u> <del>was</del> ) lost saw the deceased alive on <u>2-14</u> 19 <u>87</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I <u>was</u> <del>was not</del> ) did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>James P. Jarboe M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>2/14/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
James P. Jarboe M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		2/17/87		CHARLES MEMORIAL GARDENS, LEONARDTOWN, ST. MARY'S	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		FEB 20 1987		MD. <u>Julia Anderson-Rudness</u>	
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please send the attached pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (If burial is for removal, IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 0 5 9 0 9	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>SHIRLEY THERESA BAILEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>February 25, 1987</b>			2b. HOUR <b>2:45 P</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 25, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Leonardtowntown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TELEPHONE OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PHONE</b>			
13a. STATE <b>MD.</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>LOVEVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. BOX 4 20656</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>DONALD W. FULLER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LILLIAN I. WOODBURN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>577-26-1414</b>		17. INFORMANT ADDRESS <b>JOHN FRANKLIN BAILEY, SAME AS 13E.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular tachycardia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>7 years</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1986</b> to <b>February 25, 1987</b> that (I) (we) lost saw the deceased alive on <b>February 25, 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edwin E. Westura, M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edwin E. Westura, M.D.</b>					22e. ADDRESS <b>Leonardtowntown, MD 20650</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/28/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>QUEEN OF PEACE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HELEN ST. MARY'S MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 02 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Tindon-Rudner</b>				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

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DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

James

L.

Biscoe

2a. DATE KNOWN  
OF  
DEATH MATED XX 2-27 19 87

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH  
MONTH DAY YEAR  
Nov. 28, 1948 38 YRS.6. AGE (IN YEARS  
(LAST BIRTHDAY)IF UNDER 24 HRS  
MONTHS DAYS HOURS MIN.2c. DATE  
PRONOUNCED  
DEAD 2-28 19 872d. HOUR  
9:00  
a. M.7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

MD.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

St. Mary's County, MD

10. CITY OR TOWN OF DEATH

Lexington Park

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Rt. 235

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Security Guard

12b. KIND OF BUSINESS  
OR INDUSTRY

Motel

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland13b. COUNTY  
St. Mary's13c. CITY OR TOWN  
Lexington Park13d. INSIDE CITY LIMITS? ☐ NO ☐13e. STREET ADDRESS  
Box 644

20653

14. FATHER'S NAME

James

FIRST

MIDDLE

Anderson

15. MOTHER'S MAIDEN NAME

Grace

FIRST

C.

MIDDLE

Biscoe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

217-46-5399

17. INFORMANT

ADDRESS

Grace C. Anderson

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Contact Gunshot Wound of Head (rifle)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? (head  
& abdomen)  
YES ☒ NO ☐21a. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR MONTH DAY YEAR  
6:30 P.M. 2-27 19 8721c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  
subject shot himself

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)  
woods near

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE  
Rt. 235, Lexington Park, St. Mary's Co., Md.22a. I certify that I took charge of the remains described above, held on  
death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinionACTUAL  
SIGNATURETITLE (SPECIFY)  
M.D. Deputy Chief, MEDICAL EXAMINERDATE  
SIGNED 2-28-87EXAMINER'S NAME  
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

Mar. 4, 1987

23c. NAME OF CEMETERY OR CREMATORY

Charles Memorial

23d. LOCATION  
CITY OR TOWN

Leonardtwn St. Mary's Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

W. Clarke Mattingley Leonardtown, Md.

25a. DATE REC'D BY REGISTRAR

MAR 04 1987

25b. REGISTRAR'S SIGNATURE

COX COLLEGE



LIBRARY

*[Handwritten signature]*



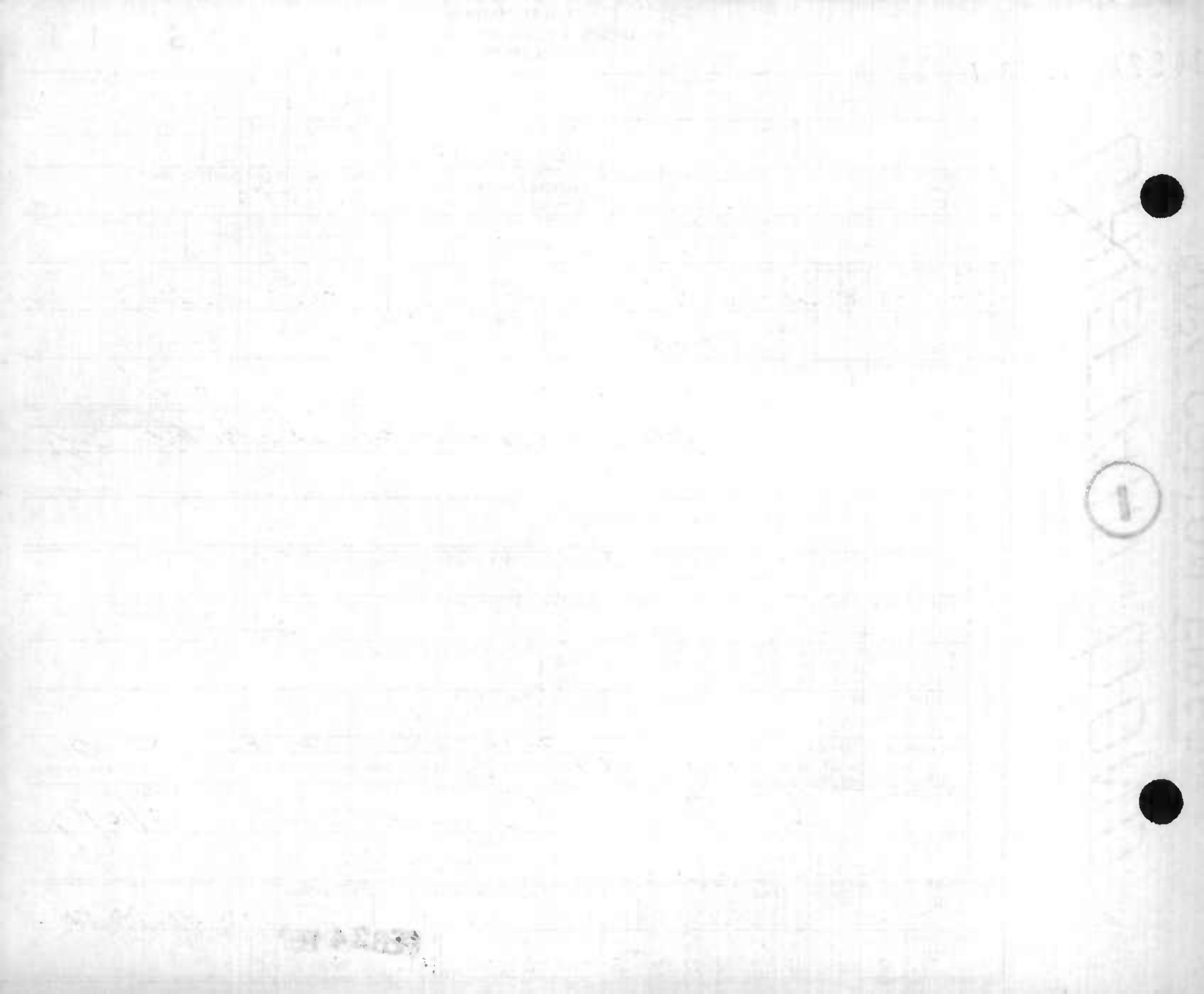
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called and a report filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 05911 REG. NO.			
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) <b>THOMAS WALTER BOND</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>February 18, 1987</b>		2b. HOUR <b>9:23A<sub>M</sub></b>	
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 24, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's</b> MD.							
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Hollywood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 2 Box 308 20636</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Bond</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nannie Briscoe</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-03-479</b>		17. INFORMANT ADDRESS <b>Emma C. Bond Same</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebrovascular Accident</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/15, 1987</b> to <b>2/18, 1987</b> , that (I) (we) lost saw the deceased alive on <b>2/18, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>David Allen</b> DEGREE <b>M.D.</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/18/87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Allen, M.D.</b>						22e. ADDRESS <b>Leonardtwn, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb. 23, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Queen of Peace</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Helen, St. Mary's, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Md.</b>						25. REGISTRAR'S SIGNATURE <b>87 05911</b>							

BP \_\_\_\_\_



046259

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05912

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Jeffries Cheuning, Jr.		2a. DATE OF DEATH MONTH DAY YEAR 2 27 87		2b. HOUR 3:25 PM	
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 29, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.	
10. CITY OR TOWN OF DEATH Charlotte Hall	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Charlotte Hall Veterans Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Retired		12b. KIND OF BUSINESS OR INDUSTRY Banking
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b. COUNTY VAA	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Jeffries Cheuning		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Page Meetze			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWS 57736-3778		17. INFORMANT ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA AND/OR URINARY TRACT INFECTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>SENIOR DEMENTIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 16</u> , 19 <u>86</u> , to <u>FEB 27</u> , 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>FEB 27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-27-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN H. WEBER, MD		22e. ADDRESS 30 X 262-C PRINCE FREDERICK MD			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE Mar. 4, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Prince Georges VA		23e. DATE RECD. BY DEPT. OF HEALTH AND MENTAL HYGIENE MAR 05 1987			
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified.

*[Faint, illegible handwriting on lined paper]*

045855 MAR - 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05913

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH				2b HOUR			
JOHN						CLIFTON		MONTH DAY YEAR 2 25 1987				M			
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d HOUR	
MALE	BLACK	AUG. 15, 1910		76 YRS.		MONTHS DAYS		HOURS MIN.		MONTH DAY YEAR 2 25 1987				M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH								MD.	
S.C.		USA				ST. MARY'S									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
LEXINGTON PARK		NAVAL HOSPITAL PATUXENT RIVER		MINISTER		CHURCH									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD.		ST. MARY'S		LEXINGTON PARK		<input checked="" type="checkbox"/> NO <input type="checkbox"/>		P.O. BOX 382 20653							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST JOHN CLIFTON				FIRST MIDDLE LAST EUNICE TINKER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
NO				218-00-5999				HATTIE M. CLIFTON SAME AS 13E.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
<i>Ventricular Arrhythmia</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
TITLE (SPECIFY)															
ACTUAL SIGNATURE _____ M.D. _____ MEDICAL EXAMINER															
DATE SIGNED 2/25/87															
EXAMINER'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D. ADDRESS LEONARDTOWN, MD.															
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				3/1/87				TRUE HOLINESS CEM.				PARK HALL, ST. MARY'S MD.			
24 FUNERAL DIRECTOR															
NAME ADDRESS															
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.															
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE															
MAR 02 1987 <i>Julia Davidson-Randall</i>															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN THE SPACE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

RECEIVED MAY 10 6:00 PM

WILLIAM H. HARRIS



5/1/13

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

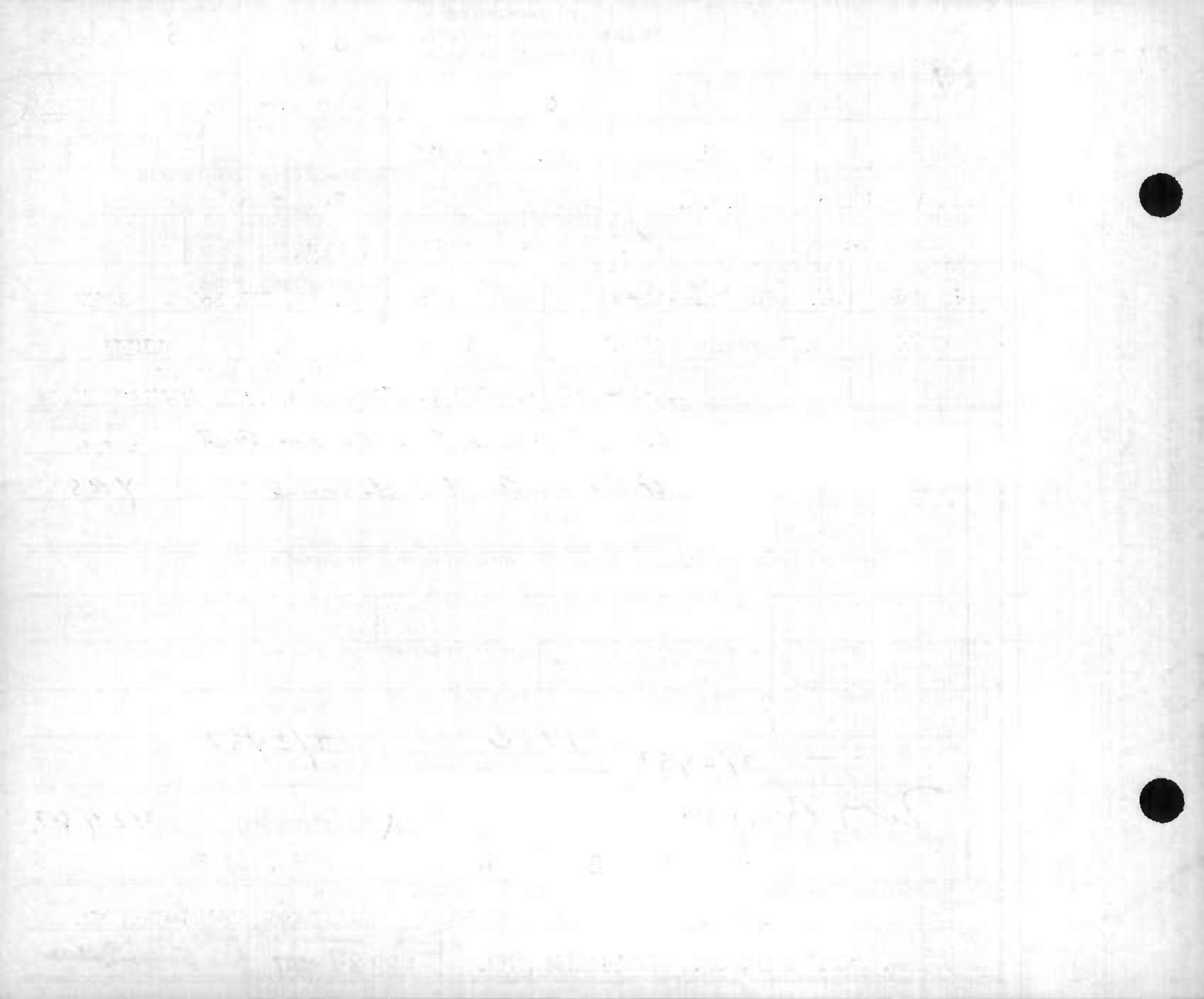
IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 5 9 1 4  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
LAURA JANE CONNORS		February 23, 1987		0902A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
FEMALE	CAUCASIAN	JAN. 3, 1916	71	St. Mary's County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
WEST VIRGINIA	U.S.A.		St. Mary's County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Leonardtwn	St. Mary's Hospital		HOMEMAKER		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
MARYLAND	ST. MARY'S	HOLLYWOOD	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
GROVER CLEVELAND ALLEN		INDIA B. LIGHT		RT. #1, BOX 365 20636	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		234-28-2292		CHARLES C. FINK, RT. #1, BOX 365, HOLLYWOOD, MARYLAND 20636	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>					<i>S-c</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive disease</i>					<i>YRS.</i>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY	21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1986</i> , 19____, to <i>2/23/87</i> , 19____, that (I) (we) last saw the deceased alive on <i>2/23/87</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE			22c. DATE SIGNED
<i>William D. Boyd</i>					<i>2/24/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
William D. Boyd, M.D. II		Leonardtwn, Md, 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
BURIAL	2/25/87	BALTIMORE NATIONAL	BALTIMORE, BALTIMORE, MD.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		FEB 27 1987		<i>Julia Davidson-Randall</i>	



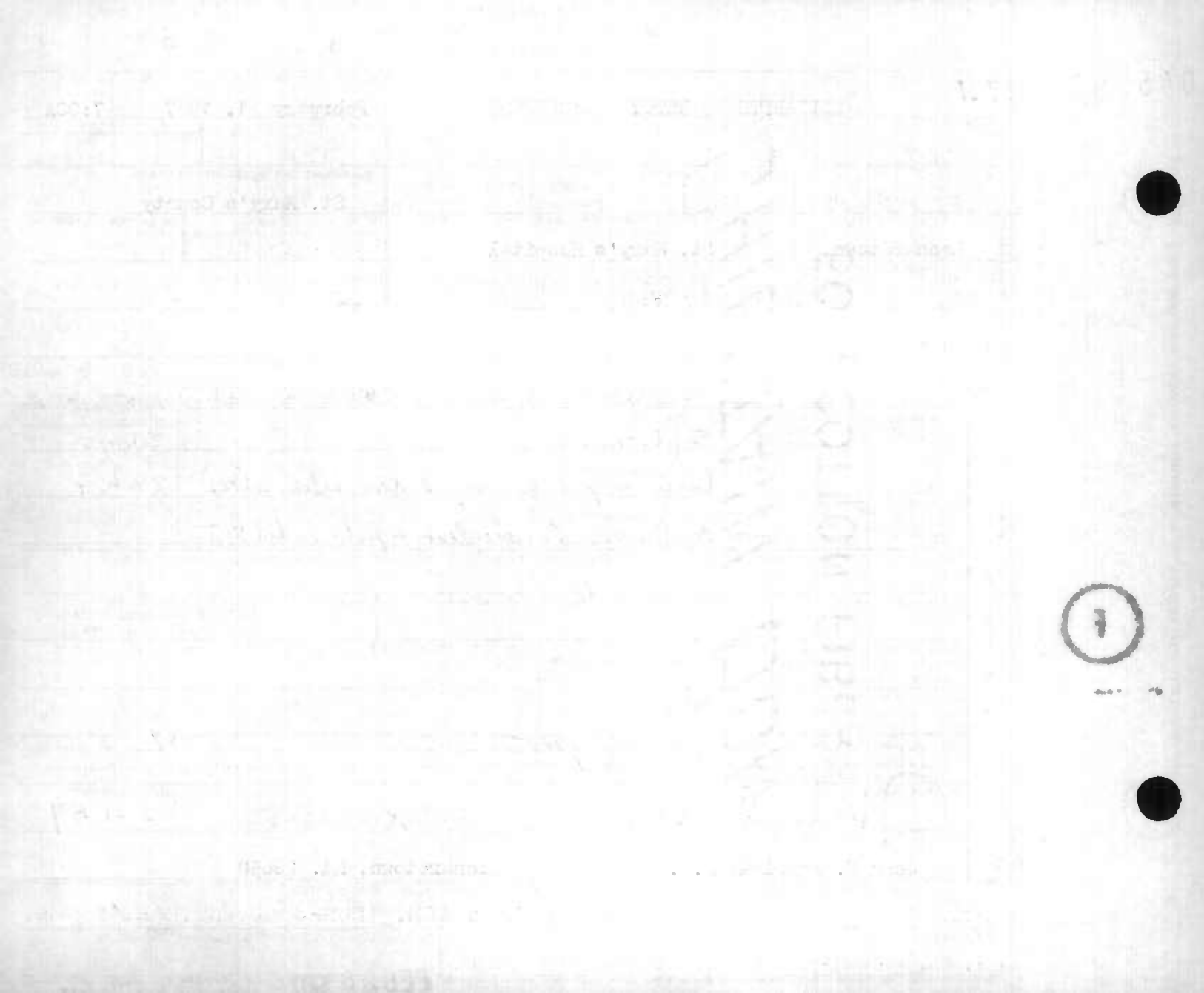


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial certificate. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 05915 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH BETTY DICKERSON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>February 21, 1987</b>		2b. HOUR <b>7:00A M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 15, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST MORLAND, VA. USA</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>ABELL</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>GEN DEL. 20606</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE A. DICKERSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY RICH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-40-8695</b>		17. INFORMANT ADDRESS <b>FRANCIS ALOYSIUS DICKERSON, ABELL, MD. P.O. BOX 124</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>large infected sacral decubitus ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular accident + prolonged bed rest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 wk +</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19____, to <b>1987</b> , that (I) (we) lost saw the deceased alive on <b>2.20</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Fenwick, M.D.</b>				22c. DATE SIGNED <b>2.21.87</b>				22d. ADDRESS <b>Leonardtwn, Md. 20650</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>2/25/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BUSHWOOD, ST. MARY'S MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please register this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's office will be notified for autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8705916 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) HARRY OSWALD DIXON SR.					2a. DATE OF DEATH MONTH DAY YEAR February 2, 1987			2b. HOUR 3:53 P.M.			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG. 31, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10. CITY OR TOWN OF DEATH Leonardtownt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND					13b. COUNTY ST. MARY'S		13c. CITY OR TOWN MECHANICSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH THOMAS DIXON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LYDIA M. JONES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-36-6853		17. INFORMANT RT. #1, BOX 308 EDNA S. DIXON, MECHANICSVILLE, MD. 20659							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Ventricular Fibrillation, Electrical Asynchronous dissociation											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Feb 02, 1987, to Feb 02, 1987, that (I) (we) last saw the deceased alive on Feb 02, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edwin E. Westura, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Leonardtownt, Maryland 20650									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/5/87		23c. NAME OF CEMETERY OR CREMATORY MT. ZION UNITED METH.		23d. LOCATION CITY OR TOWN COUNTY STATE MECHANICSVILLE, ST. MARY'S, MD.					
24. FUNERAL DIRECTOR EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.				25a. DATE REC'D. BY REGISTRAR FEB 9 1987		25b. REGISTRAR'S SIGNATURE					

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 05911  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GRANVILLE JOSEPH EVERSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 17, 1987</b>			2b. HOUR <b>0100 M</b>	
3. SEX <b>M</b>		4. RACE <b>C</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 21 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ST. MARY'S COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Mechanicsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>987 Scott Circle</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>Mechanicsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Granville Petticore Everson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ellen Mullen</b>		13e. STREET ADDRESS / ZIP CODE <b>987 Scott Circle, Mechanicsville, 20659</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1944-1946 57-09-6490</b>		17. INFORMANT ADDRESS <b>Lillian B. Everson - same as #13-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LUNG (SMALL CELL)</b> DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: <b>3 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Arteriosclerosis, Peripheral Coronary, Small Arterial Nerve Dysfunction, Parkinson's</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>DECEMBER 19 81</b> to <b>FEB 17 19 87</b> , that (1) (we) last saw the deceased alive on <b>January 15 19 87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>E. W. W. Sturza</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>02-17-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edwin E. Wüstura, M.D.</b>		22e. ADDRESS <b>19 West Jefferson St 1981 LEONARDTOWN, MARYLAND 20650</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/17/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, Pr. Geo., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hunt Funeral Home</b>		P.O. Box 156 ADDRESS <b>Waldorf, Md 20601</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the "Burial-Transit" portion. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

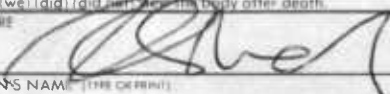
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REG. NO.


FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET GRACE FAIRFAX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEB. 12, 1987</b>		2b. HOUR <b>M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 18, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ST. MARY'S</b> MD.	
10. CITY OR TOWN OF DEATH <b>LEXINGTON PARK HOME</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD.</b>		13b. COUNTY <b>ST. MARY'S</b>	13c. CITY OR TOWN <b>GREAT MILLS</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN ALOYSIUS O'BRIEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY CATHERINE HUFT</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-07-1388</b>		17. INFORMANT ADDRESS <b>4 WALNUT COURT RUDOLPH K. FAIRFAX, LEXINGTON PARK, MD.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Colon</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE 				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. SHAH, M.D.</b>				22e. ADDRESS <b>LEONARDTOWN, MD. 20650</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>2/16/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEMORIAL GARDENS, WALDORF, CHARLES, MD.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 20 1987</b>	25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the attending physician and complies, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit is given to the funeral director by the State Registrar of Health and Mental Hygiene prior to final arrangements, or removal.

IMPORTANT: If item 21 is marked as "Not at work" or "Not at home," item 18 should show any injury, trauma, or traumatic event, the medical history of the deceased.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05919

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
KEY-ARRA						FENWICK		2-9-87		19						M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
FEMALE		BLACK		JUNE 3, 1986		8 YRS. 8						2-9-87		19						10:29a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
MARYLAND		USA										St. Mary's County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
LEXINGTON PARK		Patuxent River Hospital		NONE																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MARYLAND		CALIFORNIA				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT. 2, BOX 107-93													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
TERRY		DONALD		FENWICK		IRMA		ANN		THOMAS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		NONE		TERRY DONALD FENWICK, SAME AS 13e.																	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.																			
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
		HOUR A.M. MONTH DAY YEAR																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																	
				CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		M.D.		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED													
<u>Margie McKel</u>				Assistant				2-10-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
Margarita A. Korell, M.D.		111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE									
BURIAL		2/12/87		SACRED HEART CEM.		BUSHWOOD		ST. MARY'S		MD.											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
W. CLARKE MATTINGLEY				LEONARDTOWN, MD.		FEB 13 1987		<u>John D. ...</u>													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05920

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE HELEN LAST GASS			2a. DATE OF DEATH MONTH DAY YEAR FEB 7 1986		2b. HOUR 8:55 <sup>P</sup> <sub>M</sub>
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 13, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PALMERS, MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.		
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN COLTONS POINT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE GENERAL DELIVERY 90626	
14. FATHER'S NAME FIRST FRANK MIDDLE HENRY LAST FAUNCE		15. MOTHER'S MAIDEN NAME FIRST PEARL MIDDLE ELIZABETH LAST BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-48-8713A		17. INFORMANT ADDRESS JOSEPH NORMAN GASS SAME AS 13E.	
18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Regonal and Disorder Metastases, Extensive DUE TO, OR AS A CONSEQUENCE OF (b) Cystadriocarcinoma of ovary DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 years. 15+ years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I, this hospital) attended the deceased from 19 73 to 7 mos 19 87 that (we) last saw the deceased alive on 19 87 and that in (our) opinion death occurred on the date and hour and from the causes stated above (all we) (did not) view the body after death.					
22b. SIGNATURE John W. Roache, M.D.		DEGREE		22c. DATE SIGNED 7 mos 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Roache, M.D.		22e. ADDRESS Mechanicsville, Maryland 20659			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2/10/87	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BUSHWOOD, ST. MARYS MD.	
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.		ADDRESS		25. DATE RECEIVED BY REGISTRAR FEB 9 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

100% COTTON FIBER



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 05921	
1. FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CATHERINE HAZEL GRAVES</b>					2a DATE OF DEATH MONTH DAY YEAR <b>February 9, 1987</b>			2b HOUR <b>5:50p M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 28, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>70</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 72 HRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Leonardtown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>					13b. CITY OR TOWN <b>ST. MARY'S CLEMENTS</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>GEN. DEL. 20624</b>		
4. FATHER'S NAME FIRST MIDDLE LAST <b>ALTON MONORE QUADE</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY C. RUSSELL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-52-7857</b>		17. INFORMANT ADDRESS <b>WM. ALBERT GRAVES, SAME AS 13E.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: inline-block; vertical-align: middle;">           DUE TO, OR AS A CONSEQUENCE OF (b)            DUE TO, OR AS A CONSEQUENCE OF (c)         </div>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>2/3/87</b> , 19____, to <b>2/9/87</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/9/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William D. Boyd</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/10/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. Boyd, M.D.</b>					22e. ADDRESS <b>Leonardtown, Md. 20650</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/12/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bushwood, ST. Mary's Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. CLARKE MATTINGLEY, LEONARDTOWN, MD.</b>					25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 13 1987</b>						



45509 FEB 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 5 9 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FREDERICK ERNEST HAMPEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 20, 1987</b>		2b. HOUR <b>8:20p M</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 17, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ST. MARY'S</b> MD.	
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. MARY'S NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REPAIRMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>T.V. &amp; RADIO</b>
13a. STATE <b>NEW YORK</b>		13b. COUNTY <b>SULLIVAN</b>	13c. CITY OR TOWN <b>ROSCOE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK HAMPEL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MONIKA DREXLER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>117-03-4534</b>		17. INFORMANT <b>520 FRANKLIN ROAD CLARENCE CONKLIN, LEXINGTON PARK, MD. 20653</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Disease &amp; severe Senile Dementia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atrial Fibrillation Congestive Heart Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>87</u> , to <u>2/20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES C. BOYD, M.D.</b>		22e. ADDRESS <b>17 JEFFERSON ST., LEONARDTOWN, MD. 20650</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>2/25/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>LIVINGSTON MANOR, SULLIVAN, N.Y.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1987</b>	
25b. REGISTRAR'S SIGNATURE					





045127 FEB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

05923

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Bruce			MIDDLE W.			LAST Hufford			2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 2/		DAY 17/19		YEAR 87		2b. HOUR M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 22, 1934		6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2/ 17/19 87		24. HOUR 11:15		25. MIN. a m							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County, MD									
10. CITY OR TOWN OF DEATH Patuxent River				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Patuxent Naval Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. NAVY/RETIRED				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MARYLAND										13b. COUNTY ST. MARY'S		13c. CITY OR TOWN CHARLOTTE HALL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20622 RT. #1, BOX 96A, OAKS ROAD					
14. FATHER'S NAME FIRST MIDDLE LAST EDWIN H. HUFFORD						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST T. MARION PATE						16. SOCIAL SECURITY NO. 466-46-0118									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1953-1972				17. INFORMANT CHRISTINA R. HUFFORD, CHARLOTTE HALL, MD.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:30 PM x 2/17/ 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject driver of auto/truck collision													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 5 & 584, St. Mary's City, St. Mary, Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 2/18/87									
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/24/87				23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS				23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM, P.G., MARYLAND									
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.				ADDRESS				25a. DATE REC'D. BY REGISTRAR FEB 25 1987				25b. REGISTRAR'S SIGNATURE Alice Jordan-Randall									

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
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DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANYWAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their plate will be on the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8705924 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>VALERIE RUTH JORDAN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 6, 1987</b>				2b. HOUR <b>12:05</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 13, 1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>LEXINGTON PK.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>161 ROLLING ROAD 20653</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH EDWIN THOMPSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE GEORGIUS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-48-4232</b>		17. INFORMANT <b>161<sup>DD</sup> ROLLING ROAD ROBERT J. JORDAN, LEXINGTON PARK, MD. 20653</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intestinal Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (I) (this hospital) attended the deceased from <b>1/27/87</b> , 19____, to <b>2/6/87</b> , 19____, that (I) (we) lost saw the deceased alive on <b>2/6/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
21h. SIGNATURE <b>William D. Boyd, II, M.D.</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				21i. DATE SIGNED <b>2/7/87</b>			
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. Boyd, II, M.D.</b>				22b. ADDRESS <b>Leonardtwn, MD 20650</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>2/9/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHARLES MEMORIAL GARD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LEONARDTOWN, ST. MARY'S, MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

BP

February 2, 1907

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W. H. L.

W. H. L.

St. Mary's County

St. Mary's County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 0 5 9 2 5 REG. NO.			
1. FOR STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST KATHLEEN LULU KNOTT										2a. DATE OF DEATH MONTH DAY YEAR February 12, 1987		2b. HOUR 3:20 P.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 18, 1908		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.							
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN MADDOX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE GENERAL DELIVERY 20621					
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES EDWARD STRAUDERMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY ELLEN WELCH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-03-4422		17. INFORMANT ADDRESS 7410 MARC DRIVE THOMAS W. KNOTT, FALLS CHURCH, VA. 22042									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subendocardial Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										SPECIATE PREVIEW BETWEEN ONSET AND DEATH <u>has</u> <u>days</u> <u>days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <u>attended the deceased from</u> <u>2/12/87</u> to <u>2/12/87</u> that (I) <u>viewed the deceased alive on</u> <u>2/12/87</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>viewed the body after death.</u>													
22b. SIGNATURE <u>J. Patrick Jarboe, M.D.</u>				22c. DEGREE M.D.				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 2/14/87			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe, M.D.				22g. ADDRESS Leonardtwn, Md. 20650									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/16/87		23c. NAME OF CEMETERY OR CREMATORY FAIRFAX MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE FAIRFAX, FAIRFAX, VIRGINIA					
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.						25a. DATE REC'D. BY REGISTRAR FEB 18 1987		25b. REGISTRAR'S SIGNATURE <u>J. Patrick Jarboe</u>					

February 15, 1987

Dear

Mr. [illegible]

Dear Mr. [illegible]

I have your letter of [illegible]

and am [illegible]

Very truly yours,

[illegible]

[illegible]

[illegible handwritten text]

2/19/87

20

12/21

cc: [illegible]

[illegible]

FEB 18 1987  
FBI - [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
MILDRED CHING LACEY			February 5, 1987			4:05P M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE			WHITE			NOV. 24, 1920			66 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MD.			USA						St. Mary's County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtwn			St. Mary's Hospital			HOUSEWIFE					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD.			ST. MARY'S			CALIFORNIA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT		
JOSEPH GROVER CHING			MARY GWENDOLYN WATHEN			216-38-5156			MARY ANNE TREVINO SAME AS 13E.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)		
			Myocardial infarct			coronary artery atherosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			Diabetes mellitus								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
2-4-87			chronic cholecystitis			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			P.M.			19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK						STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 2-5-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body of the death.			22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
			A. Samadi, M.D.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
BURIAL			2/9/87			IMMACULATE HEART OF MARY LEXINGTON PARK,			ST. MARY'S MD.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W. CLARKE MATTINGLEY, LEONARDTOWN, MD.			FEB 9 1987			Julia Davidson-Randall					

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 above any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The attending physician is required to sign this certificate that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene and to the local health department, cremation, or removal.

IMPORTANT: If item 21 is marked as injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 5 9 2 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET L. LEWIS			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 9, 1987			2b. HOUR 4:45a m					
3 SEX FEMALE		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR DEC. 23, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S County, MD.					
10 CITY OR TOWN OF DEATH LEXINGTON PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMBER HOUSE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Telephone Supervisor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. STATE MD.		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN HOLLYWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 60 PINTO DR., Rt. 3			
14 FATHER'S NAME FIRST MIDDLE LAST Owen MATTINGLY				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA SHORE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-03-8009		17 INFORMANT ADDRESS BEVERLIE J. RODILL SAME AS 13E.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>cardiovascular Disease &amp; congestive Heart Failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/9/87</u> 19 <u>87</u> to <u>2/9/87</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>2/5/87</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27b. SIGNATURE <u>[Signature]</u>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <u>2/9/87</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D.						27e. ADDRESS LEONARDTOWN, MD. 20650					
23a. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial			23b. DATE February 11, 1987			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland		
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		

FEB 12 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- DECEASED NAME (TYPE OR PRINT) William L. McMahon, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 02 13 1987			2b. HOUR 2:33P <sub>M</sub>				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 18 1912		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.				
10 CITY OR TOWN OF DEATH Lexington Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Patuxent Naval Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Super. - Ret. Fed. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Dameron		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 22 20628			
14 FATHER'S NAME FIRST MIDDLE LAST William L. McMahon, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie I. Rockwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Ret. 1974		17 INFORMANT ADDRESS Mary E. McMahon Same as #13					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>XXXXXX</u> attended the deceased from <u>July 16</u> , 19 <u>86</u> , to <u>Feb. 13</u> , 19 <u>87</u> , that (I) <u>xx</u> saw the deceased alive on <u>Feb. 13</u> , 19 <u>87</u> , and that in (my) <u>x</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>x</u> (did <u>XXXXXX</u> view the body after death).							
22b. SIGNATURE <u>Bruce C. Miller</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 13 FEB 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE C. MILLER Lt MC USNR				22e. ADDRESS Naval Hospital Patuxent River Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/16/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR George p. kalas Funeral home				25a. DATE REC'D. BY REGISTRAR FEB 18 1987		25b. REGISTRAR'S SIGNATURE <u>Julia [Signature]</u>	

NOV 19 1964



NOV 24 1964

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked at (b), it shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR												
7. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR						
FIRST MARY			MIDDLE GLADYS			LAST McNEY			FEBRUARY 12, 1987			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			
FEMALE			CAUCASIAN			FEB. 16, 1899			87			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND			U.S.A.						ST. MARY'S MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
LEONARDTOWN			ST. MARY'S NURSING HOME			HOMEMAKER						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
MARYLAND			ST. MARY'S			LEONARDTOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE						
FIRST DANIEL			MIDDLE PHILLIP			LAST JOHNSON			CEDAR LANE APTS. 20650			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			RT. #1, BOX 56			
NO			219-46-5097			ANNE M. DRURY, LEONARDTOWN, MARYLAND 20650						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												
DUE TO, OR AS A CONSEQUENCE OF												
Failure of organ systems												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
Arteriosclerotic vascular disease												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
arthritis/cerebral vascular sclerosis												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (ST HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>						CITY OR TOWN			COUNTY STATE			
22. I certify that (1) the hospital attended the deceased from 19 to 19, that (2) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour (and from the causes stated above), (b) (we) (did) (did not) view the body after death.												
22a. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
EUGENE GUAZZO, M.D.						CHAPTICO, MARYLAND 20621						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
BURIAL			2/14/87			ST. ALOYSIUS			LEONARDTOWN, ST. MARY'S, MD.			
24. FUNERAL DIRECTOR						25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.						FEB 18 1987						



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05930  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carmine Anthony Palermo</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02 28 87</b>		2b. HOUR <b>3 P.M.</b>	
3. SEX <b>male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 18 06</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pittsburgh, PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County Md., MD.</b>				
10. CITY OR TOWN OF DEATH <b>Charlotte Hall</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Charlotte Hall Veterans Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Capitol</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Capitol</b>		13a. STREET ADDRESS / ZIP CODE <b>Rt. 2, Box 5 20622</b>				
13b. STATE <b>Maryland</b>		13c. COUNTY <b>St. Mary's</b>		13d. CITY OR TOWN <b>Charlotte Hall</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>XXXXXX-XX-XXXX WWII 200-09-2069</b>		17. INFORMANT ADDRESS <b>9206 Live Oak Lane, Nino Palermo-Upper Marlboro, Md. 20772</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>advanced chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> 19 <b>86</b> to <b>2/28</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>2/28</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>John H. Weider</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/28/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN H. WEIDER MD</b>		22e. ADDRESS <b>BOX 262-C PRIME FREDERICK 19-20678</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/5/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Veterans Cem. Cheltenham (Pr. Geo's) Md.</b>		
23d. LOCATION CITY OR TOWN COUNTY <b>Cheltenham (Pr. Geo's) Md.</b>		24. FUNERAL DIRECTOR <b>Richard A. Coleman - Upper Marlboro, Funeral Home Maryland 20772</b>				
25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

CHIEF OF POLICE

100-100000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LAWRENCE AUGUST PFLIEGER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>2-5-87</b>		2b. HOUR <b>5:25 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 17, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Leonardtown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Valley Lee</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Russell Road 20692</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Pflieger</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Sheaffer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>W.W. II 578-03-9649</b>		17. INFORMANT <b>Wife:</b> ADDRESS <b>20692</b> <b>Elizabeth W. Pflieger PO Box 85, Valley Lee, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Widely Locally Extensive Adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ascending Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>6+ months</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <b>Aug 11</b> , 19 <b>86</b> , to <b>Feb 5</b> , 19 <b>87</b> , that (1) (we) lost <b>Aug 5</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE <b>John W. Roache</b>					DEGREE		22c. DATE SIGNED <b>5 Feb 87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John W. Roache, M.D.</b>					22e. ADDRESS <b>Mechanicsville, Maryland 20659</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/8/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. George Church Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Valley Lee, St. Mary's, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Brinsfield Funeral Home Leonardtown, Md. 20650</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 05932  
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

1 DECEASED NAME (TYPE OR PRINT) JAMES HARRISON PRICE SR.			2a DATE OF DEATH MONTH DAY YEAR FEBRUARY 15 1987			2b HOUR M				
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR JUNE 7, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7c CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. MARY'S MD.				
10 CITY OR TOWN OF DEATH CLEMENTS, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.			13b CITY OR TOWN ST. MARY'S		13c CITY OR TOWN CLEMENTS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS GEN. DEL. 20624	
14 FATHER'S NAME FIRST MIDDLE LAST SHIRLEY PRICE			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OPHELIA COOPER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (ARMY)		16b SOCIAL SECURITY NO. 219-16-0828		17 INFORMANT MARY J. PRICE				ADDRESS SAME AS 13E.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT LYMPHOMA - ABD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 MOS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from DEPT 1984 to FEB 15 1987, that (I) (we) last saw the deceased alive on FEB 14 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Do not sign) (did not) view the body after death										
22b SIGNATURE Roy Guyther, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 2-16-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. ROY GUYTHER, M.D.				22e ADDRESS MECHANICSVILLE, MD. 20659						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 2/19/87		23c NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		23d LOCATION CITY OR TOWN COUNTY STATE BUSHWOOD ST. MARY'S MD.				
24 FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.				ADDRESS		25a DATE REC'D. BY REGISTRAR FEB 20 1987		25b REGISTRAR'S SIGNATURE Julia Deaton-Rodden		

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1949 FEB 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div style="text-align: right;">87 05933</div> <div style="text-align: center;">FOR STATE REGISTRAR</div>										
1. DECEASED NAME (TYPE OR PRINT) HARRY IGNATIUS RALEY					2a. DATE OF DEATH FEBRUARY 20, 1987		2b. HOUR 0702 M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH SEPT. 4, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.				
10. CITY OR TOWN OF DEATH PATUXENT RIVER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PATUXENT NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. COUNTY ST. MARY'S		13c. CITY OR TOWN RIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN I. RALEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN GATTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-36-8283		17. INFORMANT BOX 119, AIREDELE ROAD DOROTHY M. RALEY, RIDGE, MARYLAND 20680						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Ds</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>hr</u> <u>yes.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (d)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>65</u> to <u>2-20</u> 19 <u>87</u> , that (I) <u>last</u> saw the deceased alive on <u>2-12</u> 19 <u>87</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did not) view the body after death.										
22b. SIGNATURE <u>J. Patrick Jarboe, M.D.</u>					22c. DATE SIGNED <u>2/21/87</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. PATRICK JARBOE, M.D.		
22e. ADDRESS MEDICAL ARTS BLDG., LEONARDTOWN, MD. 20650										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/23/87		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CATHOLIC		23d. LOCATION CITY OR TOWN COUNTY STATE RIDGE, ST. MARY'S, MARYLAND				
24. FUNERAL DIRECTOR NAME ADDRESS EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.					25a. DATE RECD. BY REGISTRAR FEB 25 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation must be conducted.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05934  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY WILLIAMS SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 22, 1987</b>		2b. HOUR <b>5:25 P.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 31, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOKKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>ST. MARY'S</b>	13c. CITY OR TOWN <b>LEONARDTOWN</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>EAST KEYWAY 20650</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN F. WILLIAMS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETHEL GRIFFIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-22-2403</b>		17. INFORMANT ADDRESS <b>SUZANNE HENDERSON, P.O. BOX 202 20650 LEONARDTOWN, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive R hemorrhage Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>R Thrombotic Hemorrhagic Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>2/9</b> 19 <b>87</b> to <b>2/22</b> 19 <b>87</b> , that (1) (well) last saw the deceased alive on <b>2/22</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (s) did not view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Allen, M.D.</b>				22c. DATE SIGNED <b>2/23/87</b>	
22d. ADDRESS <b>Box 601 Leonardtown Md 20650</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/26/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHRIST EPISCOPAL</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>PORT REPUBLIC, CALVERT, MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 27 1987</b>	

BP

DEPT. OF JUSTICE

RECORDS SECTION

WASHINGTON, D.C.

February 22, 1957

2:22

Mr. J. Edgar Hoover

Director, FBI

Washington, D.C.

DO NOT WRITE IN THESE SPACES

Very truly yours,



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpages 1 and 2 and 3 should be filed with 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 5 9 3 5  
REG. NO.FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Newborn Male STACK			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1987			2b. HOUR 8:45 P.M.			
1. SEX MALE		4. RACE WHITE		3. DATE OF BIRTH MONTH DAY YEAR FEB. 6, 1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0 5 9		7. UNDER 1 YEAR HOURS MIN. 0 5	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.			
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN CALIFORNIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. 2, BOX 262A 20619	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES D. STACK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATRICIA ELAINE JANDZINSKI		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS CHARLES D. STACK SAME AS 13E.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OR DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED: WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) <i>Dr. J. Patrick Jarboe</i> attended the deceased from <i>2/6</i> <i>87</i> to <i>2/6</i> <i>87</i> that (ii) <i>Dr. Jarboe</i> last saw the deceased alive on <i>2/6</i> <i>87</i> and that in (my) <i>Dr. Jarboe's</i> opinion death occurred on the date and hour and from the causes stated above. (I <i>did</i> <i>not</i> view the body after death.)									
22b. SIGNATURE <i>J. Patrick Jarboe, M.D.</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2/7/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe, M.D.			22e. ADDRESS Leonardtown, Md. 20650						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/13/87		23c. NAME OF CEMETERY OR CREMATORY ST. JAMES CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ST. JAMES, ST. MARY'S, MD.		
24. FUNERAL DIRECTOR NAME ADDRESS W. CLARKE MATTINGLEY, LEONARDTOWN, MD.			25. DATE RECEIVED BY REGISTRAR 26. REGISTRAR'S SIGNATURE FEB 13 1987						

1000 1000 1000

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1000

1000

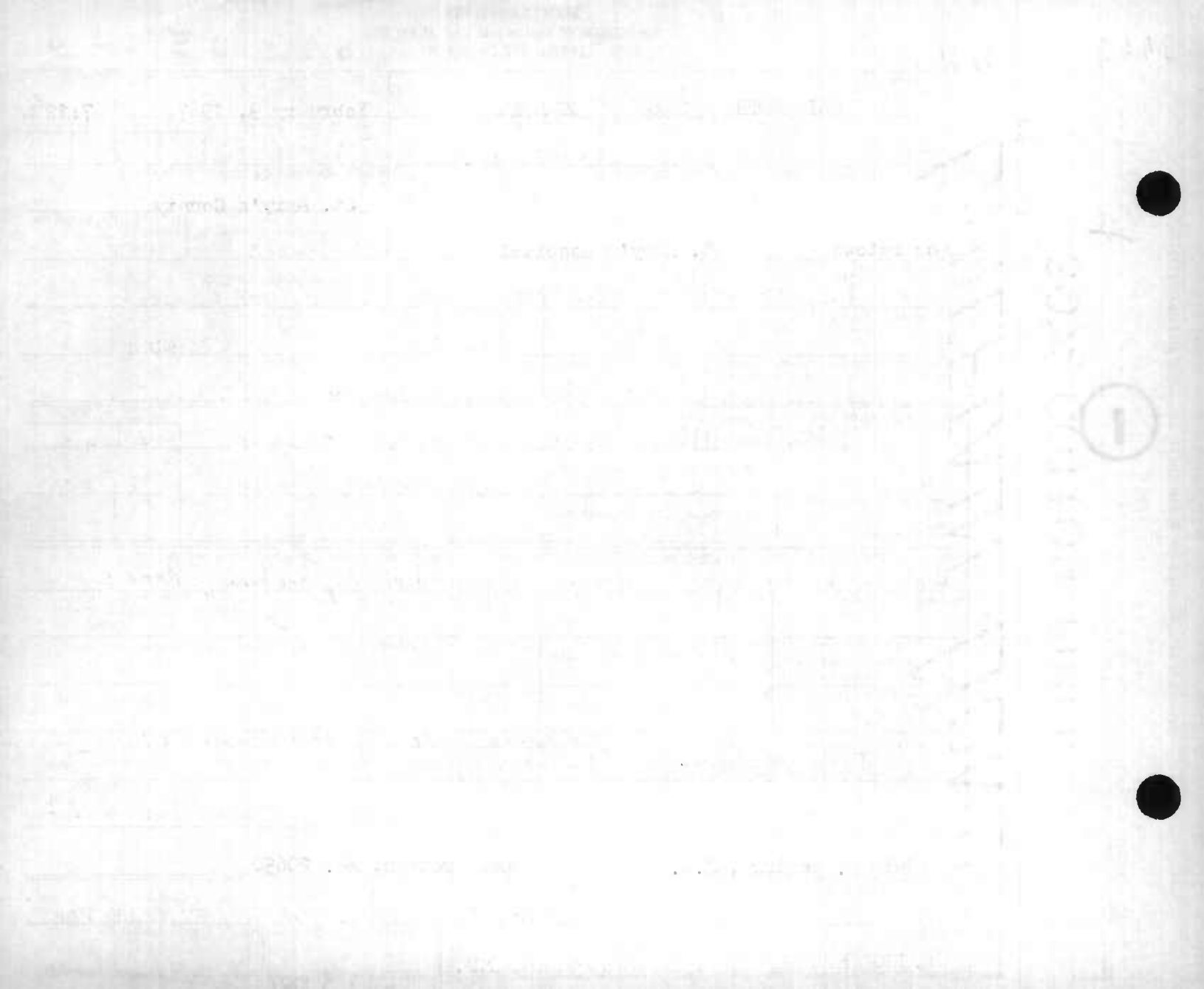
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 05230	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH SHAW STAMPER					2a. DATE OF DEATH MONTH DAY YEAR February 9, 1987			2b. HOUR 7:12 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 10, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE MD.		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEXINGTON PARK		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 146 H. Oak Court 20653			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SHAW					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA FENDER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 218-14-5986		17. INFORMANT ADDRESS BETTY S. LATHAM SAME AS 13E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CONGENITAL ANEURYSM DISSECTION DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) Diabetes Mellitus, type I; ANGINA; Myocardial Infarction; CABGS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 7 years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 1986</u> to <u>09 February 1987</u> , that (I) (we) last saw the deceased alive on <u>06 February 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 02-10-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin E. Westura, M.D.				22e. ADDRESS Leonardtown, Md. 20650							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/13/87		23c. NAME OF CEMETERY OR CREMATORY MT. CARMET CEMETERY		23d. LOCATION CITY OR TOWN GLADE VALLEY, ALLEGHANY,		COUNTY		STATE N.C.	
24. FUNERAL DIRECTOR NAME W. CLARKE MATTINGLEY, LEONARDTOWN, MD.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					



045455 FEB 27 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05937

FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Sarah Ann Taylor

2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR  
2 18 1987

2b. HOUR MIN  
4 5

3. SEX F 4. RACE B 5. DATE OF BIRTH MONTH DAY YEAR  
04-28-01 6. AGE (IN YEARS) LAST BIRTHDAY  
85 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
VIRGINIA 7b. CITIZEN OF WHAT COUNTRY?  
Prince George 8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
St. Mary's MD.

10. CITY OR TOWN OF DEATH  
Longview 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
St. Mary's Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
OPERATOR 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Oxon Hill 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS  
1300 Southview Drive 21117

14. FATHER'S NAME FIRST MIDDLE LAST  
Clarence Parker 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Elizabeth FAUNTEROY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO.  
578-48-7260 17. INFORMANT ADDRESS  
Marion Brewer, Longview, MD 20621

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Sudden Death - Prob Cardiac Arrest  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) Ischemic Heart Disease  
DUE TO, OR AS A CONSEQUENCE OF  
(c)  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
Minutes  
Years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE David C. Allen TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 2/18/87

EXAMINER'S NAME (TYPE OR PRINT) David C. Allen ADDRESS Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial 23b. DATE  
2/20/1987 23c. NAME OF CEMETERY OR CREMATORY  
Zion Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE  
Kinsale WESTMORELAND Virginia

24. FUNERAL DIRECTOR NAME ADDRESS  
W. Clarke Mattingley Leonardtown, Maryland 25a. DATE REC'D. BY REGISTRAR  
FEB 24 1987 25b. REGISTRAR'S SIGNATURE

BP DHMH - 17 (VR A15 ME (5)) 15M/77

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH ORAL PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 05938  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES BROUGHTON THOMAS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 7, 1987</b>		2b. HOUR <b>7:40A M</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 11, 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>St. Mary's County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Leonardtwn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's County</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AEROSPACE ENGINEER/CIVIL SERVICE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>LEONARDTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CYRUS BERKELEY THOMAS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GERALDINE PRIMM</b>		13e. STREET ADDRESS / ZIP CODE <b>P.O. BOX 342, LAKE DRIVE 20650</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1955-1957</b>		17. INFORMANT <b>P.O. BOX 342</b> <b>MRS. ANN B. THOMAS, LEONARDTOWN, MD. 20650</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inclastic Colon Cancer.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:27/87</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/7/87</b> 19, to <b>2/7/87</b> 19, that (I) (we) last saw the deceased alive on <b>2/7/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William D. Boyd, M.D.</b>		22c. DATE SIGNED <b>2/7/87</b>		22d. ADDRESS <b>Leonardtwn, Md. 20650</b>			
23a. BURIAL, CREMATION, REMOVAL <b>CREMATION</b>		23b. DATE <b>2/8/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HUNTT CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WALDORF, CHARLES, MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.</b>				25a. DATE RECD. BY REG. CLERK <b>FEB 11 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in separate carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 05939	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			3. SEX			4. RACE		
MILLARD REED THOMAS			February 2, 1987			MALE			CAUCASIAN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. AGE (IN YEARS LAST BIRTHDAY)			9. BALTIMORE CITY OR COUNTY OF DEATH		
WASHINGTON, D.C.			U.S.A.			86 YRS			St. Mary's MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtwn			St. Mary's Hospital			PARTS SPECIALIST			NONE		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MARYLAND			MONTGOMERY			SILVER SPRING			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
WILLIAM THOMAS			MARY McDONALD			YES			226-10-1632		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
SUSAN THOMAS (DAU.)			SAME AS ITEM #13e			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from 2/2/85, 1985, to 2/2/87, 1987, that (I) (we) last saw the deceased alive on 2/2/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE James C. Boyd, M.D.		
22c. DATE SIGNED 2/3/87			22d. PHYSICIAN (TYPE OR PRINT)			22e. ADDRESS Leonardtwn, Md			22f. MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
CREMATION						ARLINGTON NATIONAL			ARLINGTON, VA.		
24. FUNERAL DIRECTOR			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE		
VANN & WILLIAMS, 4804 GA. AVE., N.W., WASH., D.C.			FEB 9 1987			Julia Davidson-Randall					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05940	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>FLORAMAE MAUREEN WEEMS</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR	
2. SEX <b>FEMALE</b>										2b. DATE ESTIMATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR	
3. RACE <b>NEGROID</b>										2c. DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR	
4. DATE OF BIRTH <b>JUL 06 1946</b>										2d. DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR	
5. AGE (IN YEARS LAST BIRTHDAY) <b>40 YRS.</b>										2e. DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR	
6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.										2f. DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>										2g. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										2h. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2i. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
9. CITY OR TOWN OF DEATH <b>PATUXENT RIVER</b>										2j. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL, PAX RIV</b>										2k. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>										2l. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
12. KIND OF BUSINESS OR INDUSTRY										2m. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
13a. STATE <b>Maryland</b>										2n. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
13b. COUNTY <b>Calvert</b>										2o. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
13c. CITY OR TOWN <b>Lusby</b>										2p. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										2q. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
15. STREET ADDRESS <b>Box 48</b>										2r. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
16. ZIP CODE <b>20657</b>										2s. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
17. FATHER'S NAME FIRST MIDDLE LAST <b>Corelious Weems</b>										2t. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Gough</b>										2u. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										2v. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
20. SOCIAL SECURITY NO. <b>219-48-8265</b>										2w. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
21. INFORMANT ADDRESS <b>Aretha Weems Box 48 Lusby, Md</b>										2x. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										2y. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										2z. BALTIMORE CITY OR COUNTY OF DEATH <b>ST MARY'S</b> MD.	
23a. DATE OF OPERATION										23b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23c. CONDITION FOR WHICH OPERATION WAS PERFORMED?										23d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										24d. LOCATION STREET CITY OR TOWN COUNTY STATE	
24e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										24f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
24g. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										24h. TITLE (SPECIFY) M.D. MEDICAL EXAMINER	
24i. ACTUAL SIGNATURE <b>JAMES C. Boyd MD</b>										24j. DATE SIGNED <b>4/22/87</b>	
24k. EXAMINER'S NAME (TYPE OR PRINT) <b>JAMES C. Boyd MD</b>										24l. ADDRESS <b>Box 301 Leonardtown Md</b>	
24m. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										24n. DATE <b>Feb. 25-87</b>	
24o. NAME OF CEMETERY OR CREMATORY <b>St. Johns Church Cem.</b>										24p. LOCATION CITY OR TOWN COUNTY STATE <b>Lusby Calvert Md</b>	
24q. FUNERAL DIRECTOR NAME <b>Spencer E. Sewell</b>										24r. ADDRESS <b>Box 31 Prince Frederick, Md</b>	
24s. DATE REC'D BY REGISTRAR <b>FEB 25 1987</b>										24t. REGISTRAR'S SIGNATURE <b>Julia Twidson-Randall</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove additional papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 05941					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM ERNEST YOUNG										February 26, 1987		2:10A			
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR July 6 1908			6. AGE (IN YEARS LAST BIRTHDAY) YRS 78			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.						
10. CITY OR TOWN OF DEATH Leonardtwn			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Agriculture			
13a. STATE Maryland			13b. COUNTY Pr. Georges			13c. CITY OR TOWN Brandywine			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 290/20613			
14. FATHER'S NAME FIRST MIDDLE LAST William H. Young						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Wilkinson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 217-36-6832			17. INFORMANT ADDRESS Rt. 3, Box 361 Wm. G. Smith Mechanicsville, Md. 20659						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> minutes DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia</u> 2 days DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u> yrs. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> 19 <u>87</u> to <u>2/26</u> 19 <u>87</u> , that (II) (my) lost saw the deceased alive on <u>2/25</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE James P. Jarboe, M.D.						22c. ADDRESS Leonardtwn, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 2-28-87		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Church Cen				23d. LOCATION CITY OR TOWN COUNTY STATE Aguasco Pr. Geor. Md.			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home						25a. DATE REC'D. BY REGISTRAR MAR 02 1987				25b. REGISTRAR'S SIGNATURE Julia Sinden-Rudney					

